# Healthcare Transformation: Statewide and in the Treasure Valley

Corey Surber | May 2016

Saint Alphonsus

# Objectives

- Describe the primary goal of the Idaho State Health Innovation Plan (SHIP) initiative

- Identify the health policy, system and environmental change objectives of Promise Partnerships, supported by United Way of Treasure Valley

# State Health Innovation Plan (SHIP)

- $40 M federal grant from Centers for Medicare & Medicaid Innovation, awarded to Idaho for Feb. 2015 – Feb. 2019

- Work governed by Idaho Healthcare Coalition, appointed by Governor Otter
  - 43 members representing broad range of stakeholder groups
  - Chaired by Dr. Ted Epperly

# SHIP Goals

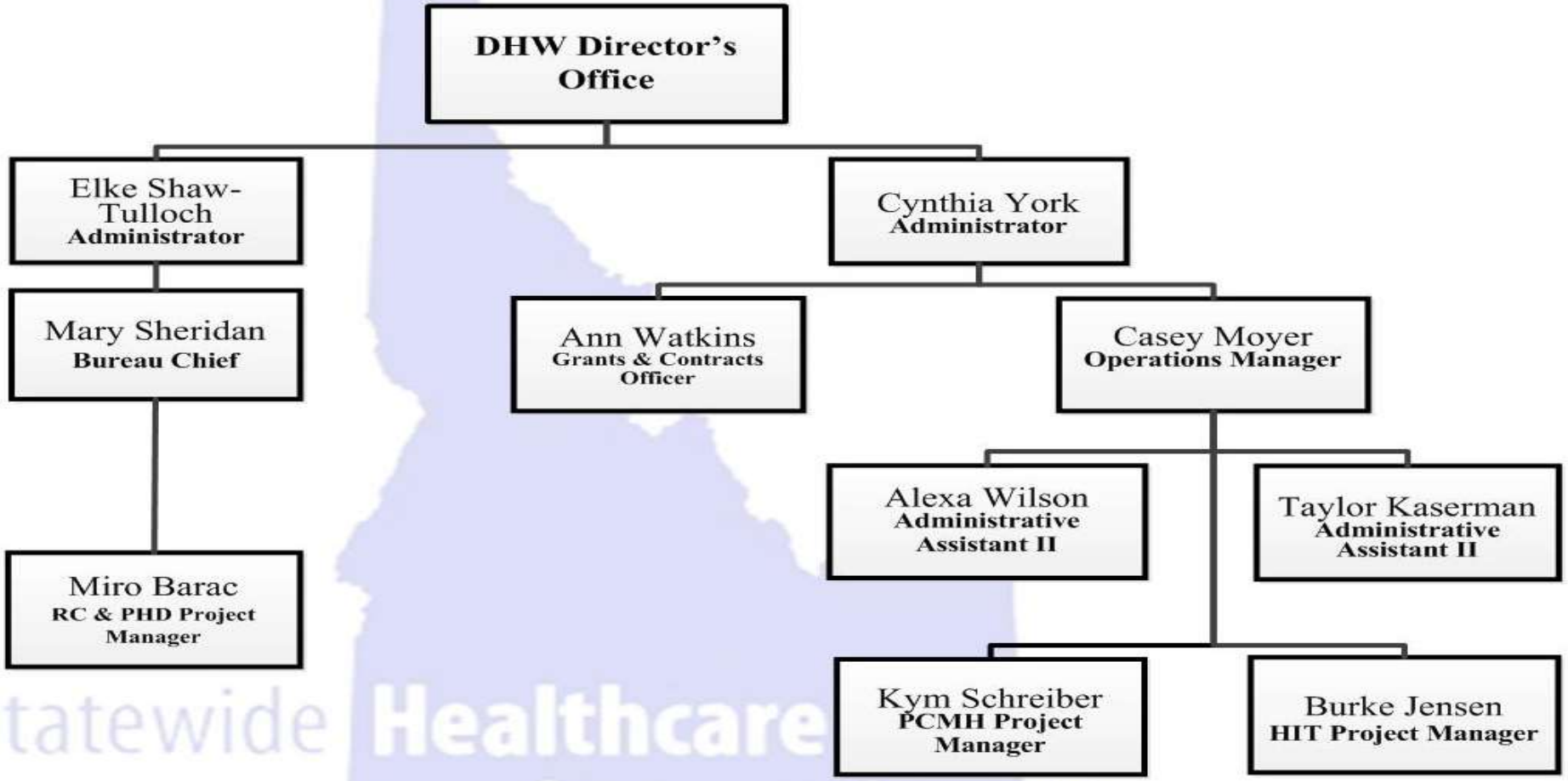
- Transform primary care practices to patient-centered medical homes
- Improve care coordination through use of electronic health records and health data connections among PCMHs
- Improve rural patient access to PCMHs by developing virtual PCMHs
- Build a statewide data analytics system
- Establish 7 Regional Collaboratives to support integration of each PCMH with broader medical neighborhood
- Align payment mechanisms across payers to transform payment methodology from volume to value
- Reduce healthcare costs

# What is a Patient-Centered Medical Home?


- Team-based approach
  - In addition to physicians and nurses, may include nurse practitioners, PAs, behavioral health staff, dietitians/nutritionists, etc.
- Provides comprehensive primary care to adults, adolescents, and children
- Broadens access to primary care, while enhancing coordination
- Population health focus

# SHIP Staff

SHIP is staffed by 8 full-time staff within IDHW, multiple contractors and regional health collaboratives



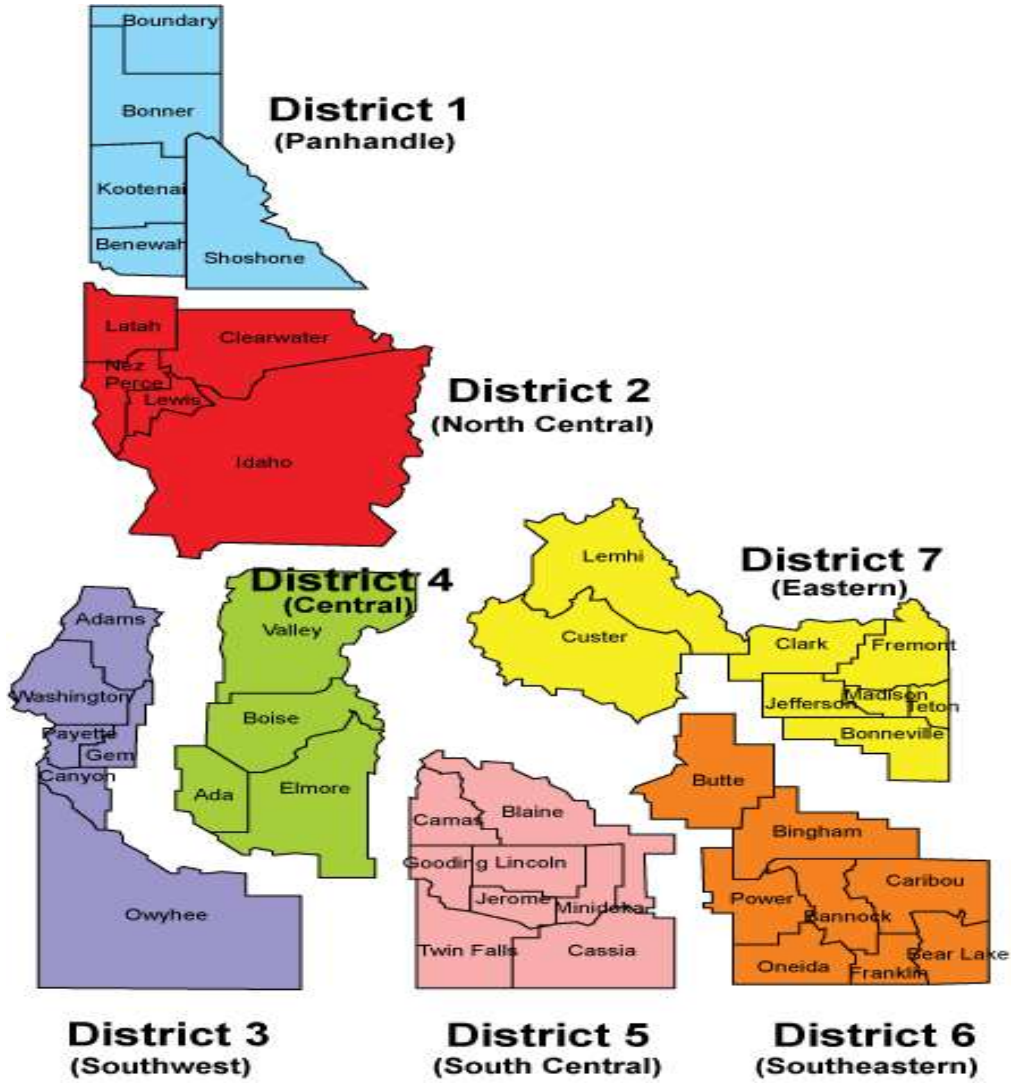
# Advisory & Work Groups

- Advisory Groups (existing entities with some overlap w/ SHIP)
  - Telehealth Council
  - Community Health EMS
  - Community Health Workers

- SHIP Workgroups
  - Multi-payer Workgroup
  - Behavioral Health Integration Workgroup
  - Health Information Technology Workgroup
  - Medical Home Collaborative Workgroup
  - Population Health Workgroup
  - Clinical Quality Measures Workgroup

# SHIP Regional Collaboratives

- Will facilitate development of medical neighborhoods
  - To strengthen patient care coordination
- Aligned with Idaho's public health districts
  - Health districts will lead integration of public health and population health management
- Community needs assessments



# Healthcare Transformation:
## Payer Perspective

PacificSource
HEALTH PLANS

# Agenda

Evolving healthcare landscape

Payer and provider incentives

Performance-based reimbursement

Contracting models

Population health management

Paradigm shift

- Case study in a community care model

# Evolving Payer Landscape

Affordable Care Act

- Health Insurance Marketplace (Exchange)
  - Individual
- Qualified Health Plans
  - Small group

Large group, fully insured

Large group, self-funded

Medicare Advantage

Medicare fee for service

Medicaid

# Unsustainable Cost Trends

New technologies

Pharmaceutical price inflation

Individual marketplace

Coverage mandates

Medical Loss Ratio limits

# Evolving Provider Landscape

Clinically Integrated Networks

- Saint Alphonsus Health Alliance
- St. Luke's Health Partners
- Portneuf Quality Alliance
- Kootenai Care Network

Accountable care organizations

Performance-based contracting

Risk sharing

Threats to the traditional hospital business model

# Value-based Payer – Provider Partnerships

Clinical leadership

Tiered plan designs and networks

Pricing differentials and Contract discounts

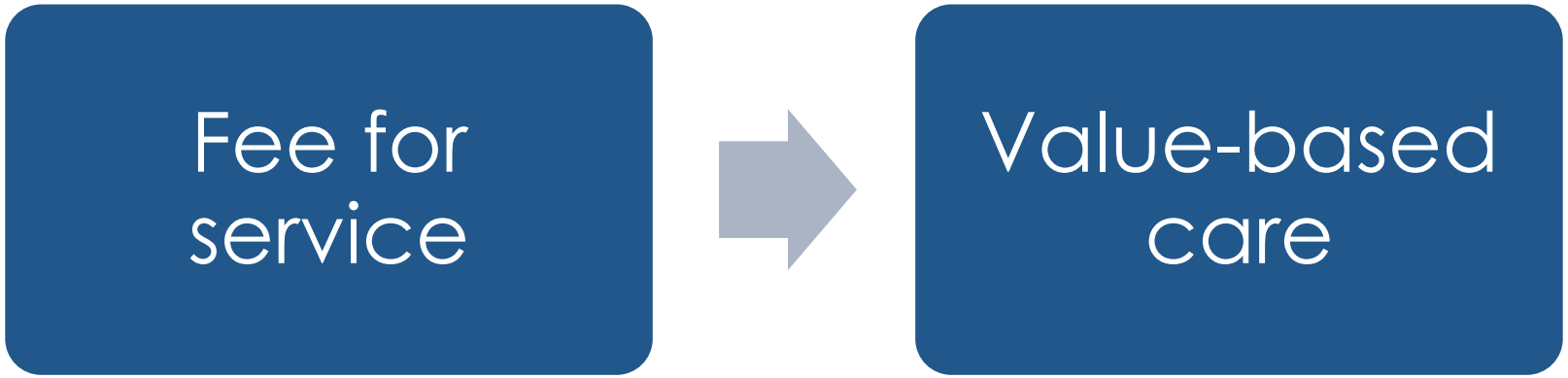
Data infrastructure

Quality, costs, and utilization measures

Innovative clinical programs

- Coordinated care management
- Medication therapy management

# Value-based Reimbursement: **Payment Reform**



# Performance Metrics

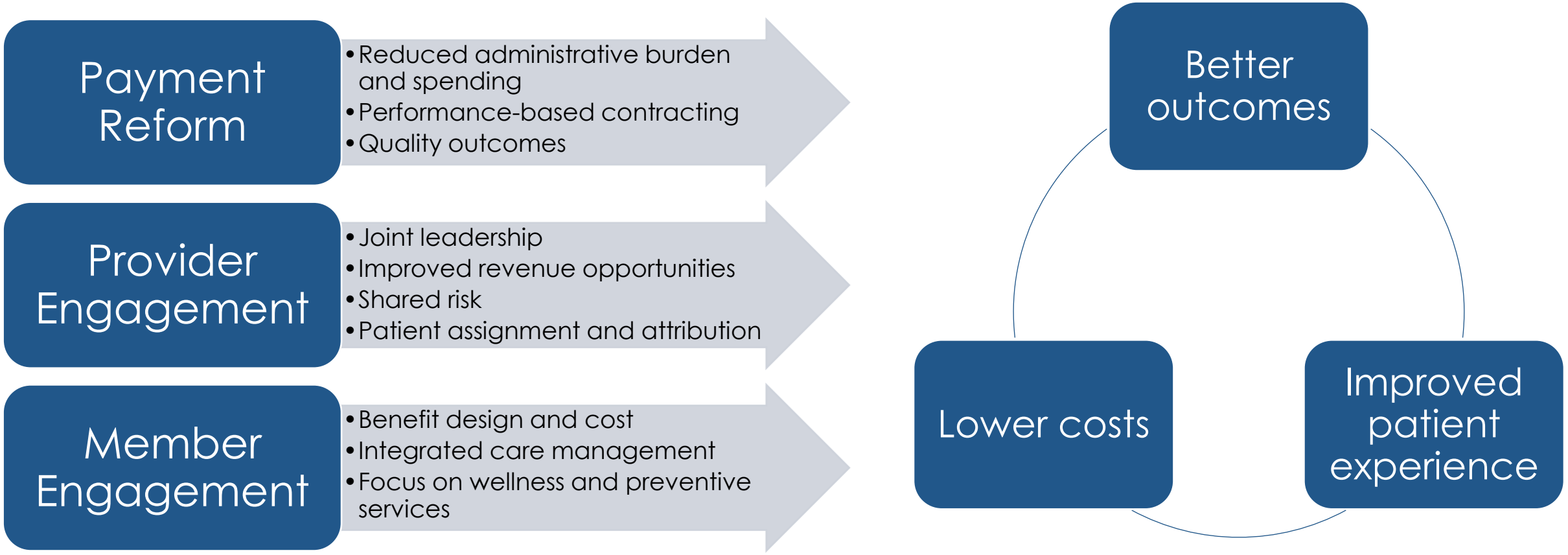
Medicare 5 Star

HEDIS

Medicaid quality incentive measures

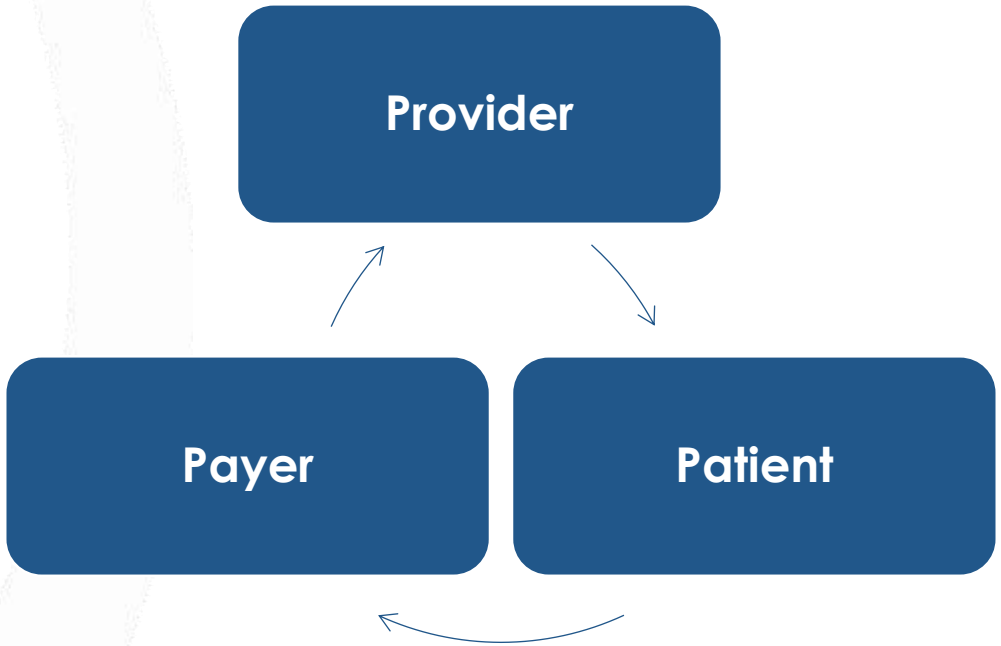
Financial outcomes

CAHPS

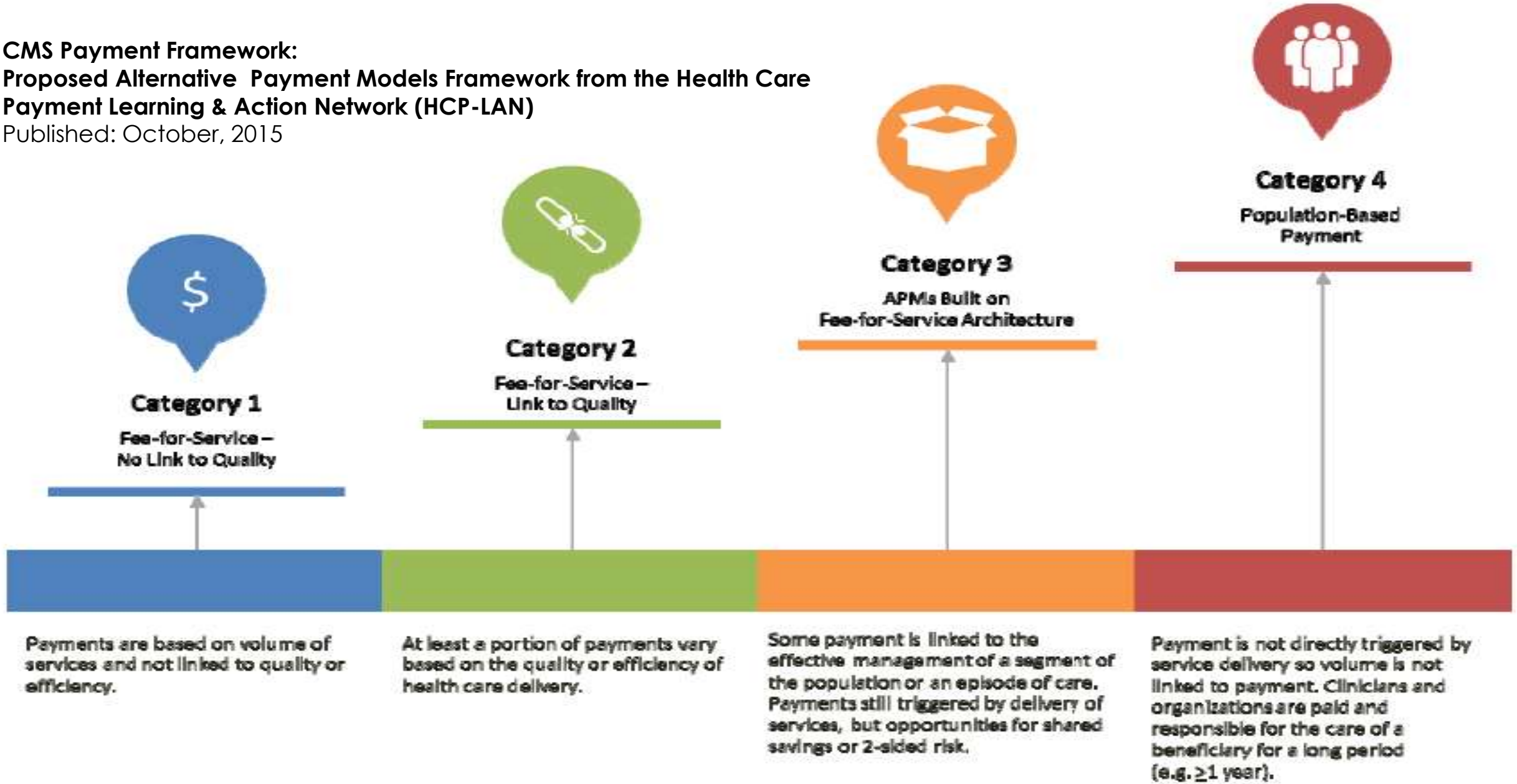

Payment Reform
• Reduced administrative burden and spending
• Performance-based contracting
• Quality outcomes
Provider Engagement
• Joint leadership
• Improved revenue opportunities
• Shared risk
• Patient assignment and attribution
Member Engagement
• Benefit design and cost
• Integrated care management
• Focus on wellness and preventive services
Better outcomes
Lower costs
Improved patient experience

# Contracting Models

When health plans and providers work together, **everyone wins.**



**CMS Payment Framework:**
**Proposed Alternative Payment Models Framework from the Health Care Payment Learning & Action Network (HCP-LAN)**
Published: October, 2015




Rajkumar R, Conway PH, Tavenner M. CMS: Engaging multiple payers in payment reform. JAMA. 2014 May 21: 311(19):1967-8.

# Value-based Reimbursement: **Saint Alphonsus Health Alliance Example**

Consists of Saint Alphonsus Health Alliance (SAHA) and independent provider groups and others, such as:

- Primary Health Medical Group
- Most community health centers, such as Terry Reilly Health Services
- Most independent providers

Builds network based on quality performance, access and credentialing standards

Contracts with PacificSource and other payers

# Value-based Reimbursement: **Saint Alphonsus Example**

Joint Leadership Meetings

Coordinated clinical workstreams

Gap reporting to identify members in need of additional care

Complex case reports

Patient claims summary data

EMR data

# Gaps in Care Report Example

| Business Line | Measure Category | Measure | Numerator | Denominator | Admin Rate | 4 Star Rate | 5 Star Rate |
|---|---|---|---|---|---|---|---|
| Medicare | ABA - Adult BMI | General Measure Data | 34 | 492 | 6.91% | 87% | 93% |
| | AMM - Antidepressant Medication Management | Effective Acute Phase Treatment | 17 | 21 | 80.95% | 0% | 0% |
| | | Effective Continuation Phase Treatment | 7 | 21 | 33.33% | 0% | 0% |
| | ART - Disease Modifying | General Measure Data | 5 | 5 | 100.00% | 78% | 88% |
| | BCS - Breast Cancer | General Measure Data | 94 | 209 | 44.98% | 74% | 81% |
| | CBP - Controlling High | General Measure Data | 0 | 297 | 0.00% | 63% | 75% |
| | CDC - Comprehensive Diabetes Care | Blood Pressure Controlled <140/80mm Hg | 0 | 155 | 0.00% | 0% | 0% |
| | | Blood Pressure Controlled <140/90mm Hg | 0 | 155 | 0.00% | 63% | 75% |
| | | Eye Exam | 33 | 155 | 21.29% | 64% | 77% |
| | | HbA1c Control (<7.0%) for a Selected | 0 | 155 | 0.00% | 0% | 0% |
| | | HbA1c Control (<8.0%) | 0 | 155 | 0.00% | 0% | 0% |
| | | HbA1c Control (<9.0%) | 0 | 155 | 0.00% | 80% | 86% |
| | | HbA1c Testing | 95 | 155 | 61.29% | 80% | 86% |
| | | LDL-C Level <100mg/dL | 0 | 155 | 0.00% | 53% | 62% |
| | | LDL-C Screening | 55 | 155 | 35.48% | 85% | 91% |
| | | Medical Attention for Nephropathy | 110 | 155 | 70.97% | 85% | 94% |
| | CMC - Cholesterol Management for Patients | LDL-C Level of <100mg/dl | 0 | 34 | 0.00% | 0% | 0% |
| | | LDL-C Screening | 18 | 34 | 52.94% | 82% | 89% |
| | COL - Colorectal Cancer | General Measure Data | 108 | 496 | 21.77% | 58% | 65% |
| | D09 - High Risk Medication | General Measure Data | 29 | 805 | 3.65% | 9% | 7% |
| | D10 - Diabetes Treatment | General Measure Data | 110 | 140 | 78.29% | 86% | 90% |
| | D11 - Medication | General Measure Data | 103 | 161 | 63.98% | 77% | 81% |
| | D12 - Medication | General Measure Data | 313 | 489 | 64.01% | 81% | 85% |
| | D13 - Medication | General Measure Data | 153 | 192 | 79.69% | 76% | 83% |
| | OMW - Osteoporosis | General Measure Data | 2 | 6 | 33.33% | 60% | 76% |
| | PCR - Plan All-Cause | General Measure Data | 3 | 35 | 8.57% | 9% | 2% |

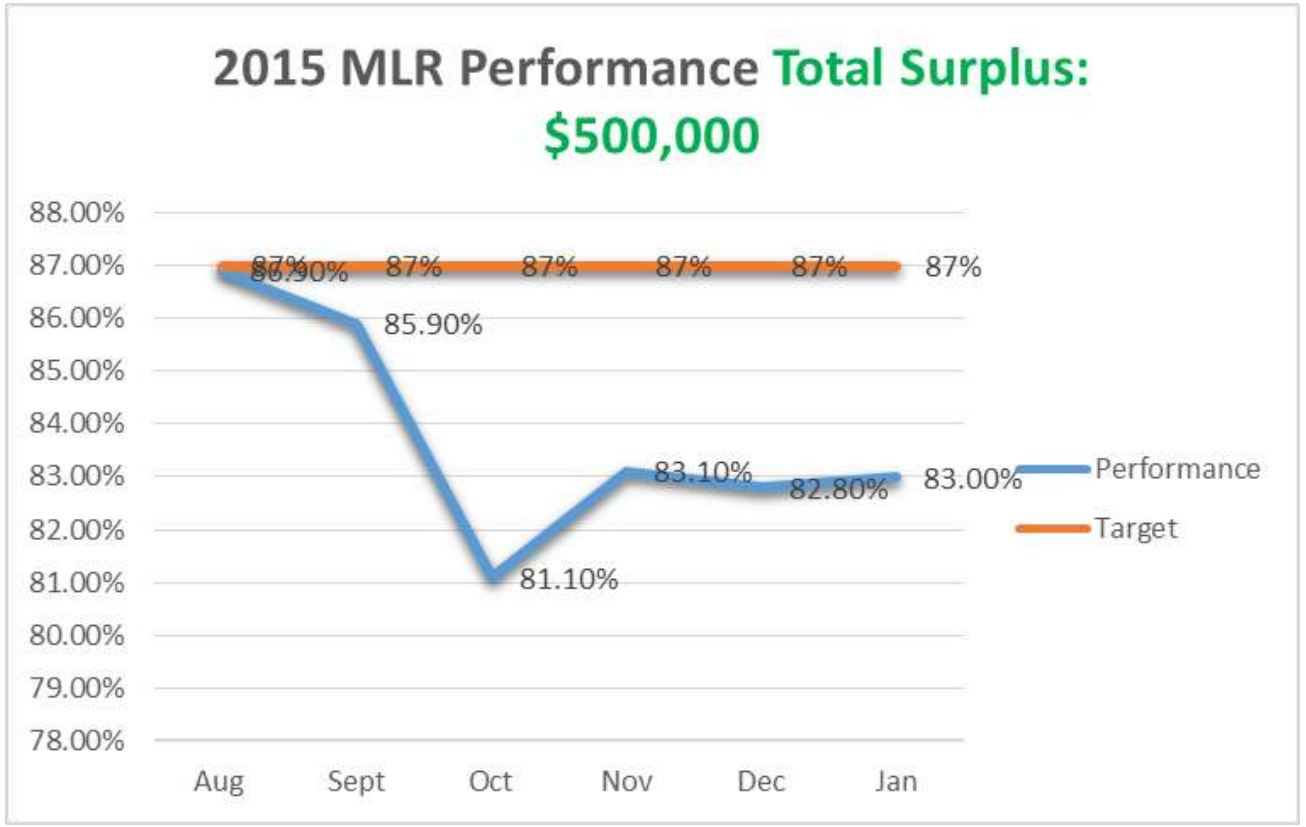
# Contract Review:
# **Surplus Sharing Example**

Set medical loss ratio target

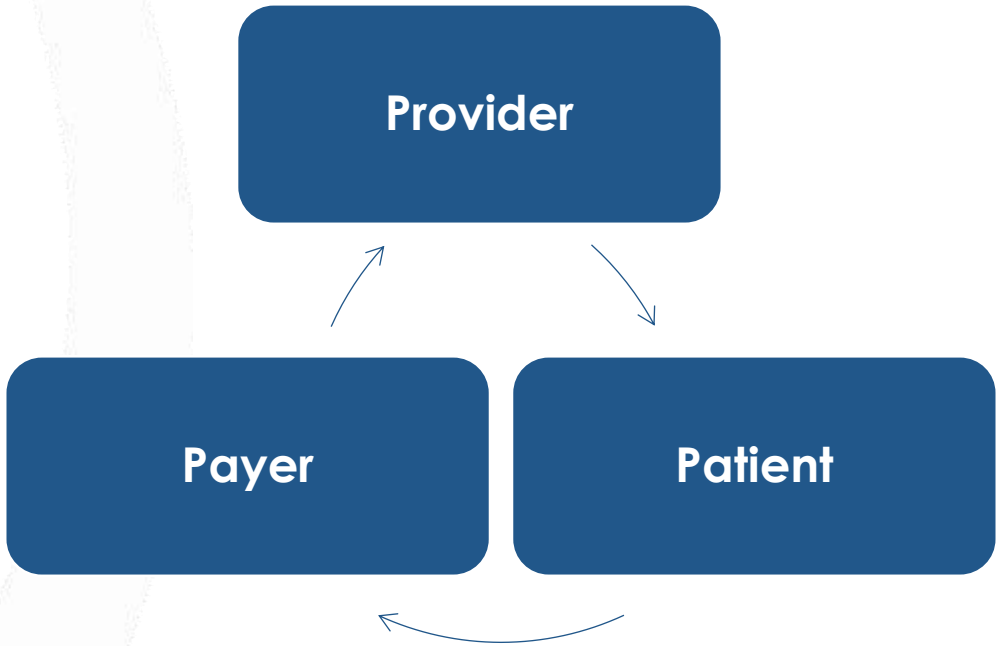
- Sharing of surplus from assigned and attributed patients
- Decreased expenses result in increased margin

Decrease Expenses

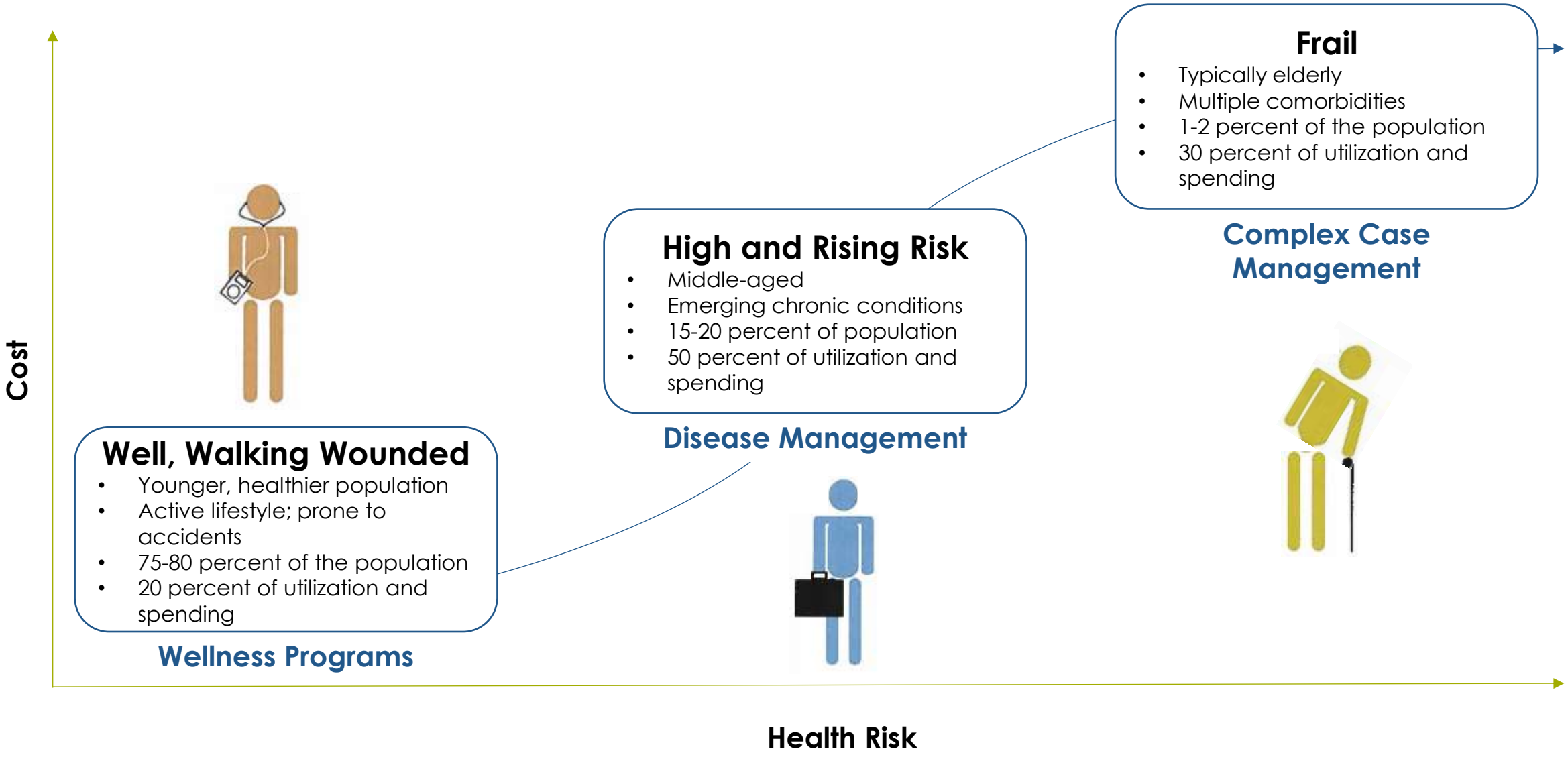
Increase Revenue



# Getting to Population Health Management, **Together.**



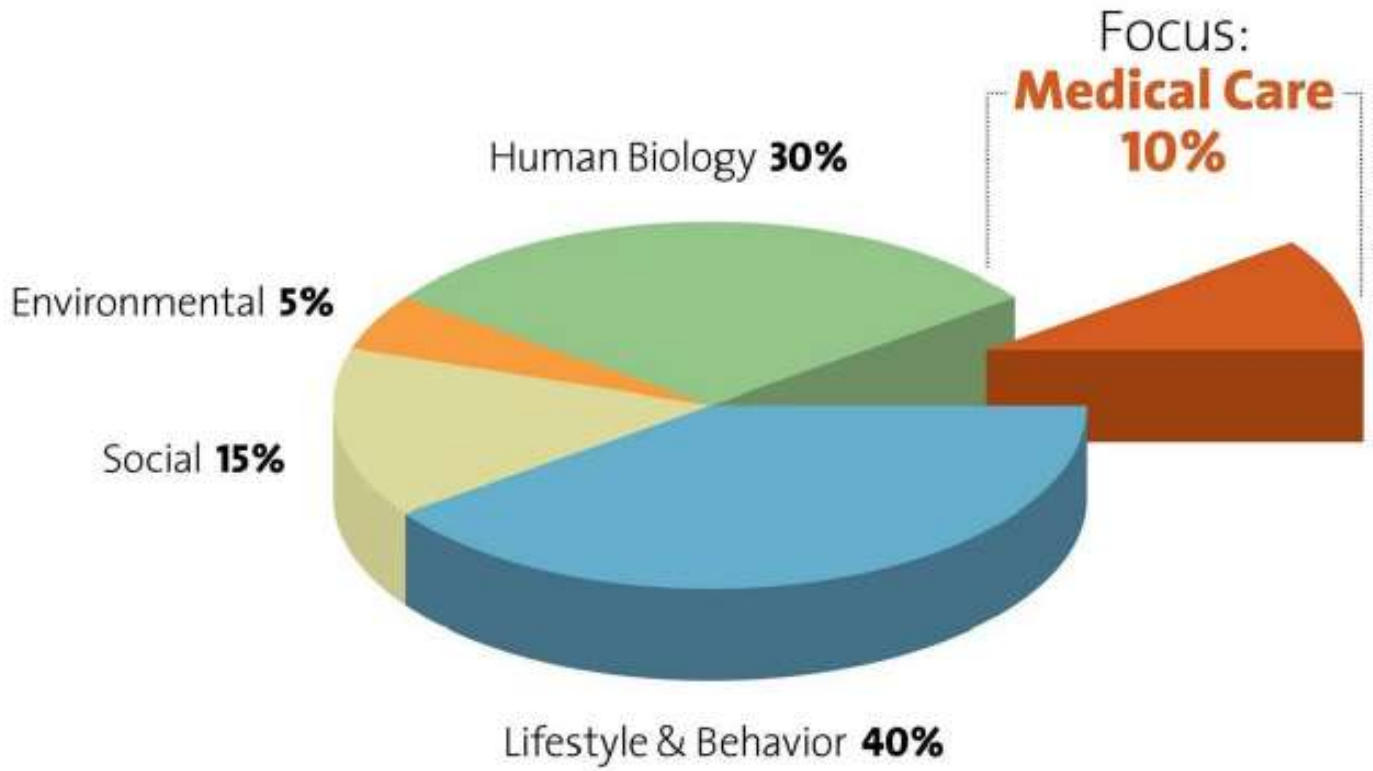
# Population Health Management



# a Community Care Model

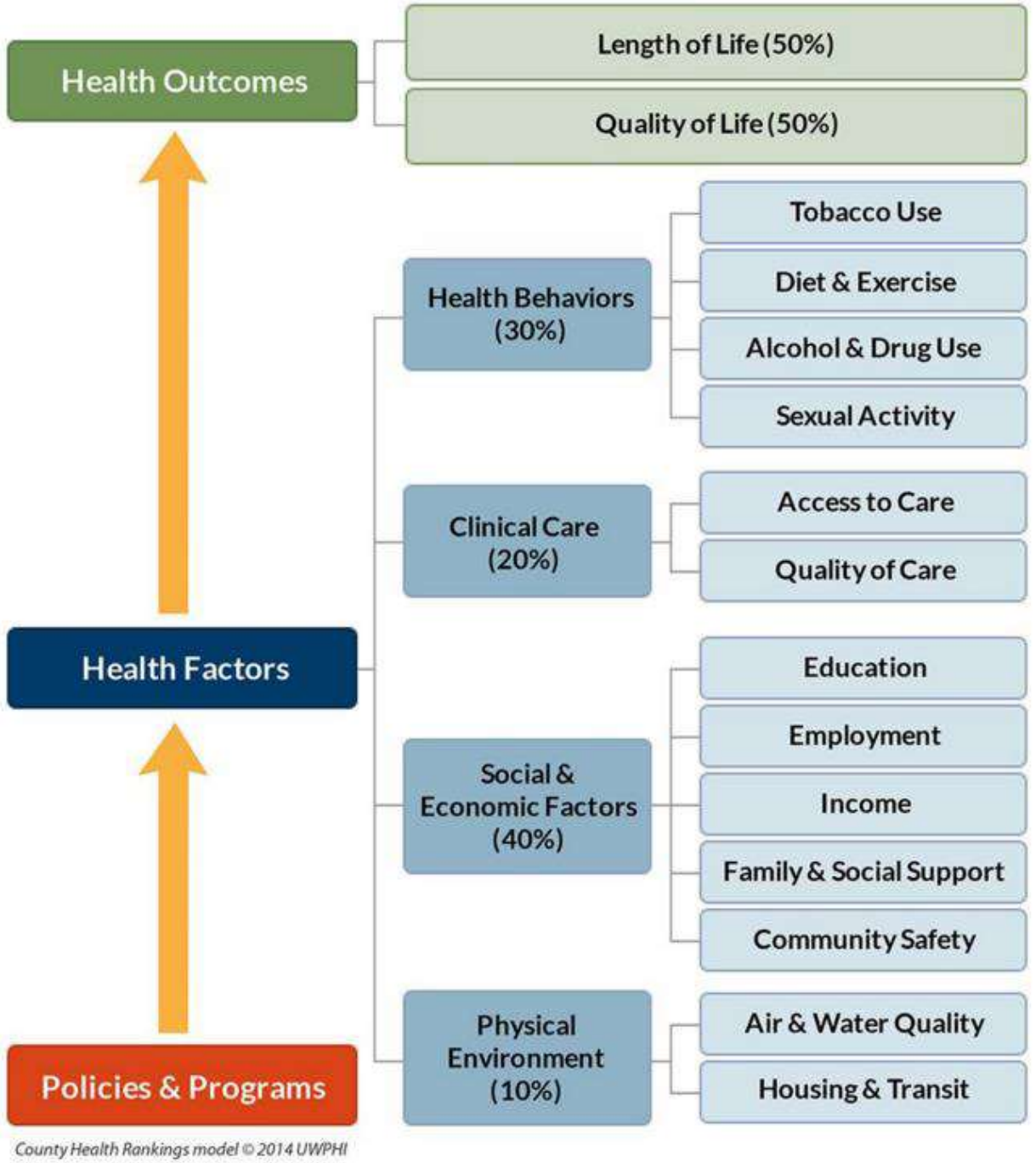
# A Paradigm Shift

# Re-thinking the Drivers of Healthcare



# Center for Consumer Engagement in Health Innovation

A consumer policy platform for health system transformation



# Center for Consumer Engagement in Health Innovation

A consumer policy platform for health system transformation

***Priority 2: Payment arrangements that incentivize people-centered healthcare***

"**First**, we must tie financial incentives directly to improvements in outcomes with particular focus on improving care for high-need/high-cost populations, reducing health disparities and adjusting payments to recognize the greater needs in low-income communities. …"

# Center for Consumer Engagement in Health Innovation

A consumer policy platform for health system transformation

***Priority 2: Payment arrangements that incentivize people-centered healthcare***

"**Second**, we must also capture a portion of current spending on medical care and redirect those resources to address the social determinants of health. Mechanisms for achieving this include hospital community benefits programs, assessment on payers or providers …. or engaging communities in allocating a portion of any shared savings realized by the health care system to meet needs the community itself identifies."

# Center for Consumer Engagement in Health Innovation

A consumer policy platform for health system transformation

***Priority 2: Payment arrangements that incentivize people-centered healthcare***

"**Finally**, we cannot ignore excessively high prices. With respect to aggregate system savings, the shift along the spectrum toward capitation will reduce the incentive to boost the overall volume of services, but high unit prices will remain a significant issue that require consumer activism. Two places in particular … prescription drugs … hospital outpatient charges…"

# **Shifting to a Community Focus:** Sick Medicine to Preventive Medicine

Wellness Foundation

- Healthy eating
- Active living
- Immunizations
- Prenatal and maternity care

Social Determinants

- Food security
- Transportation
- Housing

Primary Care

- PCMH transformation

Care Management

- Navigating a complex system

# Case Study:
# **Oregon's Coordinated Care Organizations (CCO)**

Sixteen regional coordinated care organizations

Community governance

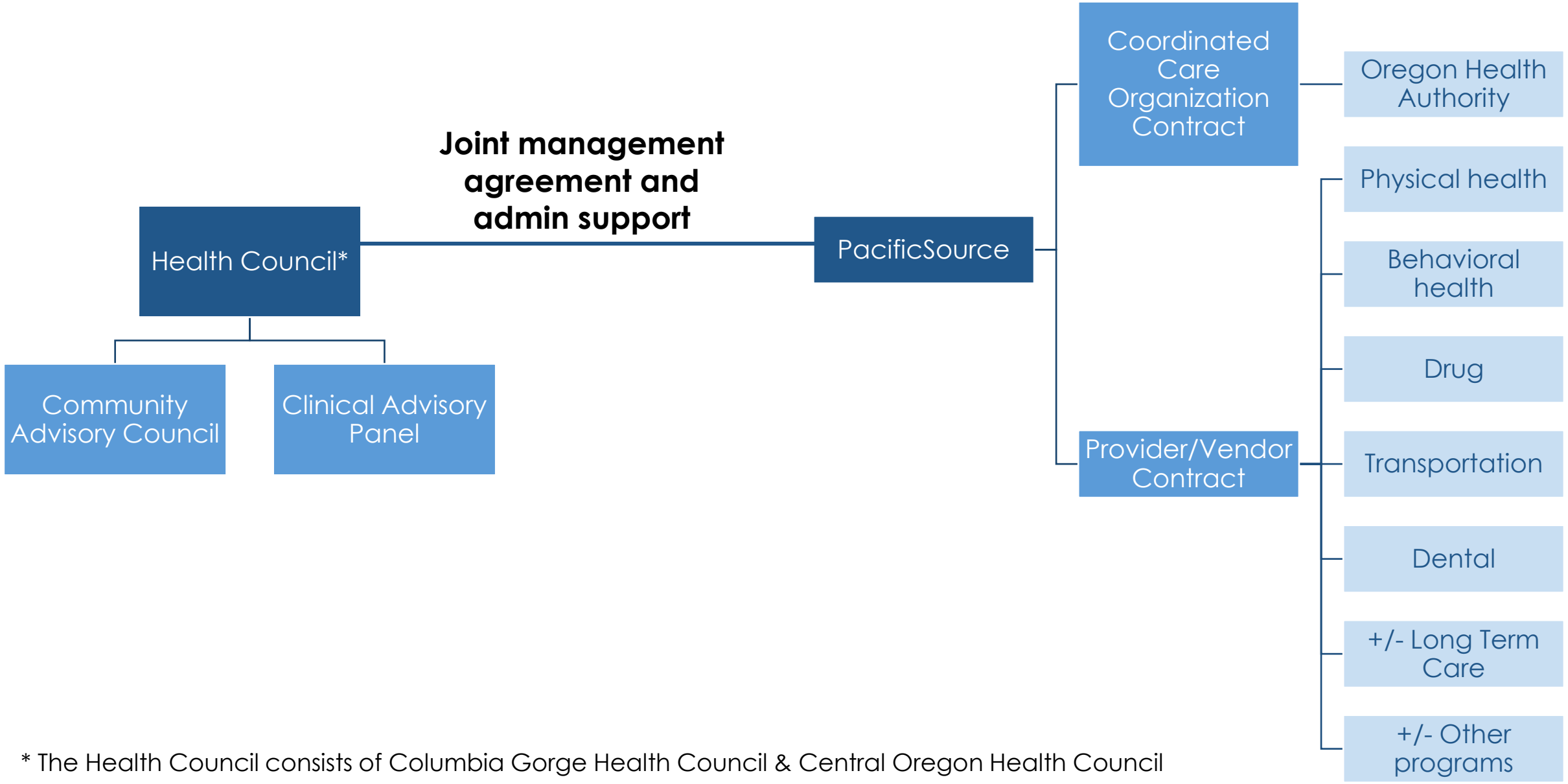
Financial transparency

Performance-based contracting

Community-shared savings

# Oregon's Coordinated Care Organizations

# PacificSource Coordinated Care Model




* The Health Council consists of Columbia Gorge Health Council & Central Oregon Health Council

# PacificSource Coordinated Care Model: **Key Points**

PacificSource is the coordinated care organization of record with Oregon Health Authority.

Community governance is required by statute and satisfied by health council oversight.

- We succeed or fail together.

Community Health Council has latitude beyond the coordinated care organization's scope to address community needs.

# Governance:
# **Health Council Board**

Elected officials

Public health director(s)

Hospital CEO(s)

Primary care provider(s)

Behavioral health provider(s)

Dental provider(s)

Health plan

Consumer(s)

# CCO Areas of Focus: **First Two Years**

Board structure

Community alignment

Quality incentive measures

- Two percent of global budget withheld
- Seventeen measures incentivized

# CCO Areas of Focus: **Transformation Plans**

Community-driven Transformation Plan

1. Integrate behavioral, dental, and physical health.
2. Develop Person Centered Medical Homes.
3. Evolve alternative payment methodologies.
4. Create community health assessment and health improvement plan.
5. Improve Electronic Health Record & Health Information Exchange adoption.
6. Ensure communication and outreach are culturally and linguistically appropriate.
7. Develop cultural competence.
8. Improve racial, ethnic, and linguistic equity.

# Outcomes

## Financially solvent after three years of operation

- Most coordinated care organizations are reinvesting money into community preventive health initiatives (food, transportation, housing, social services).

## Clinical metrics

- ↓ ED utilization is reduced
- ↑ Adolescent Well Care visits (primary care) are increased
- ↑ Immunization rates are increased
- ↑ Diabetes & Cardiovascular screening is increased
- ↑ Integrated Claims/Clinical measurements are being captured
- ↑ Colorectal Cancer Screening is increased
- ↑ Prenatal Care Rates are increased

# Questions?

# In the Treasure Valley:

# Transforming Communities Initiative

Saint Alphonsus

Trinity Health
Livonia, MI

United Way
United Way of Treasure Valley

# Transforming Communities Initiative

- Trinity Health is investing $80M in grants, loans, community match dollars and services for six communities nationwide over the next 5 years

- United Way of Treasure Valley "Promise Partnership" awarded $1.5 M over next 3 years with potential $1 M additional over subsequent 2 years

# United Way Promise Partnership Communities and Supporting Partners

- Promise Communities:
  - Caldwell
  - Boise (Vista Neighborhood)
  - Garden City
  - Nampa


- Founding Partners:
  - Saint Alphonsus
  - St. Luke's
  - Gardner Companies
  - Wells Fargo
  - Zions Bank
  - Albertsons

# Promise Partnership Concept

- Focus on areas of high need ("zip code syndrome")
- Utilize schools as "hubs" and coordinate bringing in needed community resources
- Eliminates time and transportation barriers for low income families

# Transforming Communities Grant Priorities

- Reducing impacts of tobacco and obesity through policy, systems, & environmental changes:
  - Tobacco 21
  - Complete Streets
  - Implementation of nutrition standards in early childhood settings
  - Breastfeeding policy enhancement
  - School board policy to enhance physical activity in schools
  - Food & beverage standards/ competitive foods policies


# Questions?

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